HORSES FOR HEALING INC
Mailing Address: P.O. Box 1136 * Meadow Vista, CA 95722 * Voice (530) 887-9573
Riding Center: Center Stage * 13355 Bell Brook Drive * Auburn, CA 95602

Volunteer/Staff Information Form and Health History

General information

Name: _____Date: _____

Address: _____

Date of Birth: _____ Phone: (H)_____ (W) _____

(C) _____ Email: _____ @ _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name /Address/Phone Number: _____

How did you learn about the program? _____

Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + -- Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

_____
_____
_____
_____
_____

Allergies:

_____
_____

Medications:

_____
_____
_____

Check which areas you are interested in:

Program	Special Events	Administration	
☐ Horse Handling	☐ Horse Show	☐ Public Relations	☐ Photography/Video
☐ Side-walking with a Student	☐ Fundraising	☐ Grant Writing	☐ Budget & Finance
☐ Stable Management	☐ Special Olympics	☐ Newsletter	☐ Future Planning
☐ Facility Repairs	☐ Trail Rides	☐ Volunteer Recruitment	

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____Date:_____

(volunteer/staff/caregiver)

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Name: _____

Address:_____

Phone: _____ _____Date of Birth: _____

Photo Release

☐ I DO

☐ DO NOT

consent to and authorize the use and reproduction by Horses For Healing Therapeutic Riding Center
(PATH Int'l. center)

of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N; If yes, please explain

_____

_____

I, _____ (volunteer/staff), authorize Horses For Healing Therapeutic Riding Center to
(center)

receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.
I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the PATH INTERNATIONAL center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____
(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER_____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH International center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: _____ Date: _____
(volunteer/staff)

HORSES FOR HEALING

THERAPEUTIC RIDING CENTER

Mailing Address: P.O. Box 1136 * Meadow Vista, CA 95722 * Voice (530) 887-9573
Riding Center: Center Stage * 13355 Bell Brook Drive * Auburn, CA 95602

Authorization for Emergency Medical Treatment Form

□ Participant □ Staff □ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Horses For Healing Therapeutic Riding Center (Center's Name) to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

□ Parent or Legal Guardian will remain on site at all times during equine-assisted activities
□ In the event emergency treatment is required, I wish the following procedures to take place:

_____
_____
_____

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.